STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaint IN00092018. Complaint Number IN00092018: Substantiated, Federal/State deficiencies related to the allegations are cited at F225, F226, F279 and F323 Dates of Survey: June 17 and 20, 2011 Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570 Survey Team: Vanda Phelps, RN Census Bed Type: 12 SNF 72 SNF/NF 84 Total Census Payor Type: 19 Medicare 56 Medicaid 9 Other 84 Total Sample: 5 These deficiencies also reflect state	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on June 23, 2011 by Bev Faulkner, RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on observation, record review and interview, the facility failed to thoroughly investigate and report to state agencies an injury of unknown origin for 1 of 5 residents sampled for abuse/neglect in the	F0225	Corrective Actions: An incident report on state form 6-04 has been sent to ISDH regarding the identified event. An investigation regarding safety device assessment has been	07/20/2011

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	sample of 5. (Resident T) Findings include: During the orientation tour on 6/17/2011 at 10:46 a.m., Resident T was identified by RN #2 as having recently experienced a bruise on her forehead from turning in bed. The resident was observed receiving medications at 4 p.m. There was a circular shaped bruise in the middle of her forehead just below the hairline with a fading outline of more bruising which covered the entire left half of her forehead. Resident T's clinical record was reviewed on 6/17/2011 at 2:55 p.m. Her diagnoses included, but were not limited to, Alzheimer's disease. The 5/12/2011 quarterly Minimum Data Set assessment indicated her cognitive skills were severely diminished and she required total assistance of staff for all areas of her daily living. A nursing note of 4/21/2011 at 2 p.m., indicated she was found to have a 4 cm (centimeter) by 1 cm sized, light blue, bruise along her right temple/eye area. It was documented as "unwitnessed." Interview of LPN #3 on 6/20/11 at 12:55 p.m., indicated she was called to the room by a nurse aide when the injury was first		completed. The enablers have been removed and a scoop mattress has been implemented. IDT reviewed care plan and resident is now an assist of 2 with turning and repositioning. CNA's has been educated on turning and repositioningOther residents having the potential to be affected: An audit of residents who use enablers and/or safety devices will be completed to identify other residents at risk. Any residents identified affected corrections will be completed. Systematic changes: Upon admission, quarterly and with change of condition, residents will be assessed for proper safety devices. Any potential reportable event will be brought to the attention of the Regional Director of Clinical Services and Regional Director of Operations (by the Administrator/DON) for review and reported to the ISHD in accordance to Federal Guidelines. An Accident/incident report will be completed with all occurances. Accident/incident reports will be reviewed 5 days a week (monday thru Friday excluding holidays and weekends). An invesigation will be completed by DON including final dispositon. Administrator will sign off on all accident/incident report. An in-service regarding abuse and neglect and injury of unknown origin,which includes immediate notification and who to	

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	observed. She said the injury was "a golf ball sized knot in the mid forehead...raised about 1/2 inch. The bruising hadn't started yet." Another nursing note 6/8/2011 at 1:30 p.m., indicated a nurse aide reported finding a golf-ball sized, purplish, raised knot on Resident T's forehead. Another entry, dated 6/11/2011 at 10:25 a.m., indicated, "cont (continues) to have lg (large) hematoma on forehead." 6/11/2011 at 6 p.m., indicated, "conts to have bruise covering (l) [left] side of forehead." On 6/20/2011 between 11 a.m. and 4 p.m., individual interviews of 11 hands-on staff (nurses and nurse aides) indicated Resident T was unable to move herself in bed, did not wiggle or squirm, etc. She could call out for ice cream and sometimes sang hymns, but was unable to consistently report pain or hunger. The staff indicated that actually, she rarely spoke at all. Interview with the Administrator and interim Director of Nursing on 6/20/2011 at 11 a.m., indicated this event had not been reported to ISDH (Indiana State Department of Health) or other state agencies because their internal investigation had concluded Resident T		report incident to, will be completed for staff by 7-20-11. An in-service for CNA's and licensed nurses will be completed on transfers and repositioning will be completed for by 7-20-11. The Administrator and DON will be in-serviced on accidents/incidents of unknown origin investigation outcomes/conclusion will be completed.Monitoring: Accidents and incidents will be brought to clinical triage and the daily clinical review 5 days/week (excluding holidays and weekends) for review to ensure investigation and final disposition has been completed in full to determine if there is an injury of unknown origin to ensure timley reporting. DON and/or designee will monitor all accidents and incidents on a daily basis to ensure ongoing compliance. Accidents and incidents will be reviewed during monthly QA on an ongoing basis for at least 6 months to ensure complianceDate systematic changes will be completed: 7-20-11	

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	must have hit her head on the siderail while being turned. No staff had admitted it had happened, but that was the only conclusion they could make. Their investigation indicated the resident was fine at 9 a.m., and during lunch, but at 1:30 p.m., the injury was noticed while the resident was lying in bed. The Administrator provided notes from a daily meeting on 4/22/2011 that noted the unit manager reported a Certified Nurse Aide (CNA #1) had reported she had bumped Resident T's head on the side rail when she turned her. Review of the facility's investigation of the 6/7/2011 injury of unknown origin indicated it was typed notes of staff interviews, but lacked a conclusion of any kind. An investigation regarding the 4/21/2011 event had not been conducted other than the stand up meeting notes. On 6/20/2011 at 3:30 p.m., upon review of nursing schedules and assignment sheets for 4/21/2011 and 6/20/2011, during another interview with the Administrator and interim Director of Nursing, it was noted the same nurse aide/CNA #1 had been assigned to care for Resident T on both dates. Until this time, the facility investigations had not made this connection.			

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	Review of CNA #1's personnel file on 6/20/11 at 4:47 p.m., indicated there were no disciplinary actions or teachable moment documentation in her file. Interview at the time with the Administrator and interim Director of Nursing supported this observation. CNA #1 was on a medical LOA during this investigation and not available for interview. This federal tag relates to complaint IN00092018. 3.1-28(c) 3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, record review and interviews, the facility failed to follow its abuse/neglect protocol when 1 of 5 residents sampled for abuse/neglect issues in a sample of 5 was found with a knot in the middle of her forehead. This resident was completely dependent and unable to say what had happened. Further the facility failed to report this injury of	F0226	Corrective Actions: An incident report on state form 6-04 has been sent to ISDH regarding the identified event. An investigation regarding safety device assessment has been completed. The enablers have been removed and a scoop mattress has been implemented. IDT reviewed care plan and resident is now an assist of 2 with	07/20/2011

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	unknown origin to the State Agency or to conduct a comprehensive investigation regarding the event. (Resident T) Findings include: During the orientation tour on 6/17/2011 at 10:46 a.m., Resident T was identified by RN #2 as having recently experienced a bruise on her forehead from turning in bed. She was observed receiving medications at 4 p.m. There was a circular shaped bruise in the middle of her forehead just below the hairline with a fading outline of more bruising which covered the entire left half of her forehead. Resident T's clinical record was reviewed on 6/17/2011 at 2:55 p.m. It indicated she had been a resident since 1998. Her diagnoses included, but were not limited to, Alzheimer's disease. The 5/12/2011 quarterly MDS (Minimum Data Set) assessment indicated her cognitive skills were vastly diminished and she required total assistance of staff for all areas of her daily living. A nursing note of 4/21/2011 at 2 p.m., indicated she was found to have a 4 cm (centimeter) by 1 cm sized, light blue, bruise along her right temple/eye area. It was documented as "unwitnessed."		turning and repositioning. CNA's have been educated on turning and repositioningOther residents having the potential to be affected: An audit of residents who use enablers and/or safety devices will be completed to identify other residents at risk. Changes or adaptations will be made as needed. Systematic changes: Upon admission, quarterly and with change of condition, residents will be assessed for proper safety devices. Any potential reportable event will be brought to the attention of the Regional Director of Clinical Services and Regional Director of Operations (by the Administrator/DON) for review and reported to the ISHD in accordance to Federal Guidelines. An Accident/incident report will be completed with all occurances. Accident/incident reports will be reviewed 5 days a week (monday thru Friday excluding holidays and weekends). An invesigation will be completed by DON including final dispositon. Administrator will sign off on all accident/incident reports. An in-service regarding abuse and neglect which includes immediate notification and who to report incident to, will be completed for staff by 7-20-11. An in-service for CNA's and licensed nurses will be completed on transfers and repositioning will be completed for by 7-20-11.	

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	Another nursing note 6/8/2011 at 1:30 p.m., indicated a nurse aide reported finding a golf-ball sized, purplish, raised knot on Resident T's forehead. Another entry dated 6/11/2011 at 10:25 a.m., indicated, "cont (continues) to have lg (large) hematoma on forehead." 6/11/2011 at 6 p.m., indicated, "cont. to have bruise covering (l) [left] side of forehead." On 6/20/2011, between 11 a.m. and 4 p.m., individual interviews of 11 hands-on staff (nurses and nurse aides) indicated Resident T was unable to move herself in bed, did not wiggle or squirm, etc. She could call out for ice cream and sometimes sang hymns, but was unable to consistently report pain or hunger. The staff indicated that actually, she rarely spoke at all. Interview with the Administrator and interim Director of Nursing on 6/20/2011 at 11 a.m., indicated this event had not been reported to ISDH (Indiana State Department of Health) because their internal investigation had concluded Resident T must have hit her head on the siderail while being turned. No staff had admitted it had happened, but that was the only conclusion they could make. Their investigation indicated the resident was		The Administrator and DON will be in-serviced on accident/incident reporting to ISDH in accordance to federal guidelines.Monitoring: Accidents and incidents will be brought to clinical triage and the daily clinical review 5 days/week (excluding holidays and weekends) for review to ensure investigation and final disposition has been completed in full to determine if there is an injury of unknown origin to ensure timley reporting. DON and/or designee will monitor all accidents and incidents on a daily basis to ensure ongoing compliance. Accidents and incidents will be reviewed during monthly QA on an ongoing basis to ensure complianceDate systematic changes will be completed: 7-20-11	

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	fine at 9 a.m. and during lunch, but at 1:30 p.m., the injury was noticed while the resident was lying in bed. The Administrator provided notes from a daily meeting on 4/22/2011 which noted the unit manager reported a Certified Nurse Aide (CNA #1) had reported she had bumped Resident T's head on the side rail when she turned her. Review of the facility's investigation of the 6/7/2011 injury of unknown origin indicated it was typed notes of staff interviews, but lacked a conclusion of any kind. An investigation regarding the 4/21/2011 event had not been conducted other than the stand up meeting notes. On 6/20/2011 at 3:30 p.m., upon review of nursing schedules and assignment sheets for 4/21/2011 and 6/20/2011, during another interview with the Administrator and interim Director of Nursing, it was noted the same nurse aide/CNA #1 had been assigned to care for Resident T on both dates. Until this time, the facility investigations had not realized this connection. Review of CNA #1's personnel file on 6/20/11 at 4:47 p.m., indicated there were no disciplinary actions or teachable moment documentation in her file. Interview at the time with the			

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	Administrator and interim Director of Nursing supported this observation. CNA #1 was on a medical LOA during this investigation. Review 6/20/2011 at 1 p.m., of the facility's current abuse/neglect protocol provided for review indicated the following excerpts: "Injuries of Unknown Source * The source of the injury was not observed by any person or the resident could not explain the source of the injury." "Investigation 1. Initiate the 'Accidents and Incidents: Report, Investigation, Follow-Up and Disposition' Procedure located in the manual. 2. Collect data on the Accident/Incident Report 3. Initiate the investigation: a. or an incident of unknown origin by: * Following the algorithm 'Investigation: Incident of Unknown Origin." " 3. Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and			

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	take all necessary corrective actions depending on the results of the investigation. 7. Report results of investigation to the proper authorities as required by State law, including the state survey and certification agency within five working days." This federal tag relates to complaint IN00092018. 3.1-28(a) 3.1-28(e)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interview, the facility failed to develop care plans which reflected the changing care needs of residents. Further, the care plans lacked individualization. This practice affected 3 of 4 residents reviewed for care plans in the sample of 5. (Residents L, P and T) Findings include: 1. Resident T's clinical record was reviewed on 6/17/11 at 2:55 p.m. Nursing notes indicated she'd had two incidents with an unexplained knot, abrasion and bruising to her forehead on 4/21/11 and again on 6/7/11.	F0279	Corrective Action: Resident Tcareplans have been reviewed and updated to reflect individualizion and organized manner. Resident P careplans have been reviewd and updated to reflect individualization and in organized manner. Resident L careplans have been reviewed and updated to reflect individualization in an organized manner. Other residents having the potential to be affected: Residents that reside in the facility who have a comprehensive care plan have the potential to be affected by the alleged deficient practice. An audit will be completed by 7-20-11 of residents careplan to ensure careplans reflect individuality in an organized manner. Any	07/20/2011

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	Interview with the Administrator and Director of Nursing on 6/20/11 at 11 a.m., indicated a CNA (Certified Nurse Aide) had admitted she'd rolled the resident into the siderail (which the facility calls enablers) while turning her. They had been unable to determine with certainty what had happened on 6/7/11, but attributed it to the same sort of event. Review of the care plan, dated as last reviewed on 6/16/11, indicated this issue was not care planned. The care plans were all preprinted pages and were completed by placing a checkmark in what the writer deciphered to be the most fitting place to address the need/intervention. The interim Director of Nursing indicated during an interview on 6/20/11 at 3 p.m., that this issue had been addressed under the section titled "Skin Integrity Assessment: Prevention and Treatment Plan of Care." The Assessment column listed: "At risk related to: [checkmark] Braden Risk Assessment Score at Risk (10-12) [checkmark] increase frequency of turning, [checkmark] Supplement with Small Shifts [checkmark] Maximal Remobilization,		careplans identified as deficient will be updated.Systematic changes: Careplans are initiated at admission, quarterly and with change of condition. Resident careplans will be updated and reviewed during daily clinical review 5 days/week (excluding weekends and holidays). An ongoing review of careplans will be completed during weekly careplan meetings to ensure careplans reflect the most recent heath care needs of the individual resident(s). Monitoring: The Clinical Reimbursement Coordinator and/or Clinical Reimbursement Specialist will montitor the updating, completion of and organization of the resident careplan weekly to ensure compliance. Careplans with identified concerns will be brought daily to DCR (5 days/week excluding holidays and weekends) to ensure individualization and organization. No less than 10 charts will be reviewed on a weekly basis to ensure individualization and organization x 3 months then quarterly thereafter unless the QA committee determines otherwise.Date sytematic changes wil be completed: 7-20-11	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[checkmark] Protect Heels [checkmark] Manage Moisture, Nutrition, Friction and Shear [checkmark] 6/17/11 place flat sheet at top of bed [checkmark] non-ambulatory [checkmark] bowel incontinence [checkmark] bladder incontinence [checkmark] see appropriate Mood and Behavior Symptoms Assessment/Plan of Care [checkmark] See Plan of Care, Pain Management, [checkmark] See appropriate Depression Mood and Behavior Symptom Assessment Plan of Care, [checkmark] dermal fragility [checkmark] shear, mid spine healed 5/23/11 [checkmark] skin tear LFA (left forearm) [checkmark] Alzheimer's [checkmark] Dementia [checkmark] splints bilateral hand [checkmark] 6/9/11 bruise to left side forehead [checkmark] pain, stiffness [checkmark] tender joints, swollen joint [checkmark] osteoarthritis [checkmark] pulse irregularities [checkmark] bladder incontinence [checkmark] dementia [checkmark] verbal impairment [checkmark] visual impairment [checkmark] cardiovascular meds			

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	155132	A. BUILDING 00 B. WING	06/20/2011

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	[checkmark] antipsychotic meds [checkmark] Hoyer for transfer needed." The goals were checked as follows: [checkmark] 6/17/11 will not develop skin integrity issue from (illegible word) skin against Stat III mattress [checkmark] will demonstrate healing without signs/symptoms of infection [checkmark] will remain free of open areas [written in] resident will be turned and repositioned without injury [written in] staff to use draw sheet and be aware of bed placement [checkmark] will be free of a serious injury if a fall would occur The interventions were checked as follows: [checkmark] complete push tool weekly [checkmark] complete Braden Scale upon admission and weekly times 4 wks, quarterly and with change of condition [checkmark] Use Commercial Moisture Barrier [checkmark] Use Absorbent Pads or Diapers that Wick & Hold Moisture [checkmark] Supplement with Multi-Vitamin (should have vitamin A, C, & E) [checkmark] Consult Dietitian prn (when needed) [checkmark] Elevate HOB (head of bed)			

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	no more than 30 degrees [checkmark] use Lift Sheet to move Resident [checkmark] Protect Elbows and Heels if being Exposed to Friction [checkmark] Maintain Good Hydration [checkmark] Avoid Drying the Skin [checkmark] Bathe with mild soap, rinse, and dry thoroughly [checkmark] moisturize skin with lotion to keep the skin soft and pliable, especially bony prominence [checkmark] keep skin clean, dry, and free of body wastes, perspiration, and wound drainage [checkmark] encourage ambulation and mobility as tolerated [checkmark] provide ROM (Range of Motion) as applicable [checkmark] position body with pillows and/or other support devices [checkmark] keep linen dry and wrinkle free [checkmark] protect elbows and heels as needed [checkmark] position calves on pillows to elevate heels off of the bed [checkmark] See ADL/Mobility Plan of Care [checkmark] Lift--do not slide resident [checkmark] use assistive device to reduce friction and facilitate resident movement such as: turning sheets, overbed trapeze, resident lift, etc			

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	[checkmark] See Alteration in Urinary Continence/Plan of Care [checkmark] See Alteration in Bowel Elimination/ Plan of Care [checkmark] Monitor Nutrition and hydration status [checkmark] See Medication Administration Record (MAR) [checkmark] Monitor wound weekly and PRN [checkmark] See Skin Grid--Pressure/Venous Insufficiency Ulcer/Other [checkmark] Provide treatment per MD order [checkmark] Update MD within 2-4 weeks if no evidence of healing [added] Undershirts on during transfers with use of solid Hoyer pad to prevent shearing on mid-spine [added] Geri-sleeves per MD order [added] Bacitracin per MD order [added] Staff to be educated on proper T/R during resident care to prevent future bruising during CNA check offs [checkmark] See Cardiovascular Circulatory Plan of Care [checkmark] See ADL/Mobility Plan of Care [checkmark] See Plan of Care: Pain Management [checkmark] See Alteration in Bowel Elimination Assessment/Plan of Care [checkmark] See Alteration in Bladder			

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	Continence Plan of Care [checkmark] Lock bed wheels [checkmark] High back wheelchair, tilt back wheelchair [checkmark] night light [checkmark] non skid socks There were multiple duplications and interventions which were not relevant for Resident T. Further one intervention said to avoid drying the skin and the very next intervention said to dry thoroughly. Some interventions related to ambulation, which this resident could not do. 2. Review of Resident L's record was done on 6/17/11 at 1:17 p.m. The 5/27/11 annual RAI (Resident Assessment Instrument) indicated this resident is cognitively intact and able to communicate well. She had one fall without injury since the previous review. The care plan contained an entry regarding falls was as follows: The problem statements were as follows: [checkmark] antidepressant [checkmark] antipsychotic [checkmark] neuralgia [checkmark] peripheral vertigo [checkmark] tardive dyskinesia [checkmark] sciatica [checkmark] peripheral vertigo (listed			

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	again) [checkmark] gait disturbance The goal was identified as: [checkmark] will be free of a serious injury if a fall would occur The interventions were listed as follows: [checkmark] must use walker -- verbal reminders -- education on proper use [checkmark] See ADL/Mobility Plan of Care [checkmark] Reacher to assist with pick up [checkmark] Lock bed wheels [added] Swina shoes for shower--tennis style shoes/ non skid footwear [checkmark] non skid socks [added] keep room free of clutter Review of the nursing notes indicated Resident L had fallen as follows: 4/2/11 While being accompanied to her room, resident said she was getting weak, knees buckled and she fell. 4/8/11 Resident lost balance while talking on telephone in front lounge. Fell and bumped head on cabinet. 5/9/11 Resident missed the chair when she sat down and fell. 5/25/11 Resident stumbled in shower			

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	room when getting ready to use commode. These four falls reflected problems of balance, seating oneself and sudden weakness. The above care plan addressed the general topic of falls, but failed to specifically address the issues which seemed problematic for Resident L except mention of the walker. If the problem was that the resident did not use her walker, it was not addressed. 3. Resident P's clinical record was reviewed on 6/17/11 at 2:20 p.m. His diagnoses included, but were not limited to, history of falls, blind, very hard of hearing, Parkinson's Disease and diabetes. His 4/19/11 annual RAI indicated his cognition was severely impaired and he required heavy to full staff assistance for all areas of daily living. He had one fall without injury since the previous review. Resident P's care plan indicated it had been rewritten 5/6/11. The following was the entry addressing falls. "Fall/Injury Assessment: Prevention and Management Plan of Care" The assessment column was as follows: "[checkmark] pain [checkmark] stiffness			

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	[checkmark] unsteady [checkmark] cardiovascular diagnosis [checkmark] bowel incontinence [checkmark] bladder incontinence [checkmark] dementia [checkmark] hearing [checkmark] visual [checkmark] cardiovascular meds [checkmark] antidepressant [checkmark] antipsychotic [checkmark] Parkinson's" The goal was checked as "will be free of a serious injury if a fall would occur." The interventions were listed as follows: [checkmark] See Cardiovascular Circulatory Plan of Care [checkmark] [checkmark] See ADL/Mobility Plan of Care [checkmark] See Plan of Care: Pain Management [checkmark] See Alteration in Bowel Elimination Assessment Plan [checkmark] See Alteration in Bladder Continence Plan of Care [checkmark] chair alarm [checkmark] bed against wall [checkmark] non skid socks It did not address how his cognition or being blind or complete dependence might impact his falling.			

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	During interview with the interim Director of Nursing on 6/20/11 at 3 p.m., she acknowledged the care plans were difficult to follow and the preprinted forms did not encourage staff to individualize the entries. She stated "I realize they're almost identical to each other and I did talk to the (corporate) regionals about them, but this is a corporate decision. I can't change them myself." This federal tag relates to complaint IN00092018. 3.1-35(b)(1) 3.1-35(d)(1) 3.1-35(d)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, record review and interview, the facility failed to ensure side rails were not used except as necessary for resident safety. This impacted 1 of 5 residents reviewed for safety in the sample of 5 in that siderails were being used although observation and the resident's assessment indicated she could not use them. (Resident T) Findings include: During the orientation tour of 6/17/11 at 10:46 a.m., Resident T was identified by RN #2 as having recently had a knot on her forehead because she hit it on the siderail while being turned. She was further identified at the time as requiring total care from staff. She was observed lying in the middle of her bed which was an air mattress. Both side rails were in the up-position. They were the 1/4 sized rails which this facility called "enablers." Clinical record review for Resident T was completed 6/17/11 at 2:55 p.m. Her 5/12/11 quarterly MDS (Minimum Data Set) assessment indicated she was completely dependent on staff for all aspects of her daily living and was severely impaired cognitively. She could not communicate her needs. Individual staff interviews were	F0323	Corrective Actions: An incident report's for resident T on state form 6-04 has been sent to ISDH regarding the identified event . An investigation regarding safety device assessment has been completed. The enablers have been removed and a scoop mattress has been implemented. IDT reviewed care plan and resident is now an assist of 2 with turning and repositioning. CNA's have been educated on turning and repositioningOther residents having the potential to be affected:A audit was completed to identify other residents that may be affected by alleged deficient practice. Any residents identifed will be evaluated for appropriate use of enablers and/or safety devices and implemented or discontinued according to assessment. Family notification will be completed. Physician order will be obtained. Careplans will be updated as appropriate. Systematic changes: side rail and assistive device assessments will be completed upon admission, quarterly, and with change of condition for appropriate placement. Side rail and assistive devices rounds will be completed weekly x 4 and monthly x 2 and then quarterly. Completed by DON/designee for compliance unless otherwise determined by the QA team.Monitoring: Director of Nursing and/or designee will monitor for completion and compliance of above audits and	07/20/2011

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	conducted 6/20/11 between 11 a.m. and 4 p.m. Five certified nurse aides, one registered nurse and three licensed practical nurses all indicated Resident T could barely move a muscle by herself. She never wiggled or scooted in the bed. She had to be turned side to side and never attempted to do that herself. She could not pull herself over by using the siderail. A nursing note of 4/21/2011 at 2 p.m., indicated she was found to have a 4 cm (centimeter) by 1 cm sized, light blue, bruise along her right temple/eye area. It was documented as "unwitnessed," but interview with the Administrator on 6/20/11 at 3 p.m., indicated a nurse aide had admitted she'd bumped the resident's head on the siderail when she turned her. Another nursing note 6/8/2011 at 1:30 p.m., indicated a nurse aide reported finding a golf-ball sized, purplish, raised knot on Resident T's forehead. Another entry, dated 6/11/2011 at 10:25 a.m., indicated, "cont (continues) to have lg (large) hematoma on forehead." 6/11/2011 at 6 p.m., indicated, "cont. to have bruise covering (l) [left] side of forehead." The facility's internal investigation had been inconclusive, but they had surmised the resident had bumped her head on the siderail during		placement of assistive devices. Completed round Audit trends will be reviewed at monthly QA.Date systematic changes will be completed: 7-20-11	

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	care. During interview 6/20/11 at 11 a.m., the interim Director of Nursing indicated they had discussed this situation that morning and decided to pad the siderails. She indicated the nurse aides did not want them removed because they were afraid the resident would roll out of the bed when they turn her. Review of her weight indicated Resident T weighed 89 pounds on 6/14/11. This federal tag relates to complaint IN00092018. 3.1-45(a)(1)			